SPECIAL BULLETIN
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Missouri MEDICAID Bulletin

www.dss.state.mo.us/dms

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INVALID DIAGNOSIS CODES

For all claims received on or after April 1, 2001 the following list of diagnosis codes will no longer be accepted. Claims must be submitted with the appropriate fourth or fifth digit diagnosis code as defined in the ICD-9-CM code book. The ICD-9-CM code book may be ordered from:

St. Anthony's Publishing, Inc.
P.O. Box 96561
Washington, DC 20090
(800) 632-0123

Or

Medicode Publications
P.O. Box 27116
Salt Lake City, UT 84127-0116
(800) 999-4600

005	386	578	786
170	401	583	798
208	410	584	799
230	413	590	806
233	414	592	810
234	424	598	820
241	427	707	821
242	428	714	871
245	429	715	887
250	459	719	895
278	465	720	896
293	466	724	897
300	491	729	946
303	492	741	959
318	518	747	977
331	528	754.7	987
332	531	758	989
344	532	780	991
345	540	782	994
348	562	785	998
365	574		

NEWBORN CARE

Effective for all claims with date of service April 1, 2001 the "YG" modifier is no longer required when billing CPT Codes 99431, 99432, 99433, and 99435.

PRIOR AUTHORIZATION REQUIRED

Effective for all claims with date of service June 1, 2001 or after the following CPT Codes will require prior authorization.

Procedure Code	Types of Service
67900	2, N
*67901	2, N
67902	2, N
67903	2, N
67904	2, N
67906	2, N
67908	2, N
67909	2, N

*Currently requires prior authorization.

NERVE TEASING PREPARATIONS

Effective immediately the reimbursement rate for procedure code 88362 is as follows:

Type of Service	Amount
I	$ 54.90
R	$ 91.70
5	$146.60

PIN-FEED CLAIM FORMS

The Division of Medical Services is in the process of changing the form style of the HCFA-1500, UB-92, Dental ADA, and Pharmacy paper claim forms. These forms are currently provided as two-part, continuous pin-feed forms. The new forms will be provided as single cut sheet forms that can be used in any standard printer that uses bond paper.

The current pin-feed forms will be available for ordering until approximately April 1, 2001. At that time, the pin-feed forms will no longer be available and all requests will be filled with the new cut sheet style claim forms.

If you are currently using the pin-feed forms on an impact printer and wish to continue using claim forms supplied by Verizon Data Services, you will need to make the necessary changes to move your print jobs to a printer that uses cut sheet bond paper. Please note that the content of the forms has not changed and all boxes inside the margin remain the same.

Verizon will continue to accept pin-feed forms, although they will not be supplying them after April.

If you wish to avoid these changes and would like information regarding electronic billing, please contact Verizon Data Services at (573) 635-3559.

BILATERAL PROCEDURES

Bilateral procedures that are performed at the same operative session must be billed with the modifier "50" added to the five-digit procedure code. The following procedure codes have been identified as bilateral procedures.

Procedure Code	Covered Types of Service
11471-50	D, G, N, S, W, 2, 9
15822-50*	D, G, N, S, W, 2
15823-50*	D, G, N, S, W, 2
15832-50*	D, G, N, S, W, 2
15833-50*	D, G, N, S, W, 2
15834-50*	D, G, N, S, W, 2
15835-50*	D, G, N, S, W, 2
15836-50*	D, G, N, S, W, 2
15837-50*	D, G, N, S, W, 2
15840-50	D, G, N, S, W, 2, 8, 9
49495-50**	D, G, N, S, W, 2, 8, 9
49496-50	D, G, N, S, W, 2, 8, 9
49501-50	D, G, N, S, W, 2, 8, 9
49507-50	D, G, N, S, W, 2, 8, 9
49250-50**	D, G, N, S, W, 2, 8, 9
49521-50	D, G, N, S, W, 2, 8, 9
49525-50**	D, G, N, S, W, 2, 8, 9
49540-50	D, G, N, S, W, 2, 8, 9
49550-50**	D, G, N, S, W, 2, 8, 9

49553-50	D, G, N, S, W, 2, 8, 9
49555-50**	D, G, N, S, W, 2, 8, 9
49557-50	D, G, N, S, W, 2, 8, 9
49560-50**	D, G, N, S, W, 2, 8, 9
49561-50	D, G, N, S, W, 2, 8, 9
49565-50**	D, G, N, S, W, 2, 8, 9
49566-50	D, G, N, S, W, 2, 8, 9
49568-50	2, 8
49570-50**	D, G, N, S, W, 2, 8, 9
49572-50	D, G, N, S, W, 2, 8, 9
49650-50**	D, G, N, S, W, 2, 8
49651-50**	D, G, N, S, W, 2, 8
49659-50**	D, G, N, S, W, 2, 8

* Prior Authorization Required
**Second Surgical Opinion Required

IMMUNIZATION SCHEDULE

The attached schedule (attachment II) indicates new recommendations for childhood immunizations. The Recommended Childhood Immunization Schedule was developed by the Advisory Committee on Immunization Practices (ACIP). State Medicaid agencies are required by Section 1905 (r) (1) of the Social Security Act to provide appropriate immunizations under the Early Periodic Screening Diagnosis and Treatment (EPSDT) program, also known as the Healthy Children and Youth (HCY) Program, according the ACIP schedule. This schedule is reviewed annually by the advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

Below are noted changes in the Immunization schedule. Please refer to page two of the schedule for additional information.

- Pneumococcal Conjugate vaccine has been added.

Appropriate immunizations must be provided during a full HCY screening unless medically contraindicated or refused by the parent or guardian of the patient. The provider may bill for a full HCY screen if all other screening components are performed and it is documented in the medical record that the appropriate immunizations were not provided due to medically contraindicated or refusal by parent or guardian.

ELECTRONIC CLAIM SUBMISSION, CREDIT ADJUSTMENTS, ELIGIBILITY VERIFICATION AND REMITTANCE ADVICES VIA THE INTERNET

Providers may now submit claims, credit adjustments, access Missouri Medicaid eligibility files, and receive their Remittance Advices via the Internet. The web site address is www.emomed.com. This web site also allows for claim status and check inquiries as well as having several public files available for viewing or downloading.

Providers are required to contact the Verizon Data Services help desk at (573) 635-3559 to obtain authorization to access this site by completing the Application for Missouri Medicaid Internet Access Account. This application may also be downloaded from the Missouri Medicaid Provider Manuals at www.dss.state.mo.us/dms.

Providers wishing to obtain authorization to access the web site must be an enrolled electronic billing provider in addition to completing the Application for Missouri Medicaid Internet Access Account. For verification of electronic billing provider status, providers may contact the Provider Relations Communication Unit at (800) 392-0938 or (573) 751-2896. Providers wishing to enroll as an electronic billing provider may contact the Verizon Data Services help desk at (573) 635-3559 or the Provider Enrollment Unit at (573) 751-2617.

MC+ HEALTH PLANS

In accordance with the MC+ contract, MC+ health plans are required to provide to MC+ enrolled individuals all medically necessary services contained in the standard benefit package. MC+ health plans are required to keep immunizations and Healthy Children and Youth (HCY) screening's current according to schedules as specified by the Missouri Division of Medical Services.

CHANGES IN MENTAL HEALTH SERVICES FOR UNINSURED PARENTS WITH ME CODES 76, 77, 78 AND 79

Page 4 of Special Bulletin, Vol. 21, No. 4, dated 1-22-99, stated individuals with a ME code of 76, 77, 78 and 79 were limited to 30 inpatient days and 20 outpatient days for the following mental health services: Community Mental Health, FQHC, Home Health, Inpatient, Outpatient, Psychiatrist, and Rural Health Clinic. **This restriction no longer applies.** This is the only change in coverage for the uninsured parent population.

Psychology/Counseling in an independent practice, Comprehensive Day Rehabilitation, Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) and Community Psych Rehabilitation, along with other non-covered services listed on page 3 of Special Bulletin, Vol. 21, No. 4, dated 1-22-99, remain non-covered for the uninsured parent population.

MC+ MANAGED CARE FOR THE CENTRAL MC+ MANAGED CARE REGION

Effective March 1, 2001, the State of Missouri will continue a managed care health care service delivery program in Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Randolph, and Saline counties. MC+ managed care serves individuals meeting specified eligibility criteria. Refer to Attachment 1 for a listing of MC+ managed care eligible group.

Effective March 1, 2001, the State of Missouri will include individuals who participate in the Mentally Retarded and Developmentally Disabled (MRDD) waiver and meet the specific eligibility criteria as referenced in Attachment 1 in the MC+ Managed Care Program in the Central Region.

CENTRAL REGION MC+ HEALTH PLANS

New contracts have been awarded for the Central MC+ managed care region. The following MC+ health plans will provide services for the MC+ Managed Care Program in the Central region:

HEALTH CARE USA HEALTH PLAN
10 South Broadway Street, Suite #1200
St. Louis, MO 63102
Provider Relations: 800/625-7602
Fax: 573/761-7380

MISSOURI CARE HEALTH PLAN
2404 Forum Blvd.
Columbia, MO 65203
Provider Relations: 800/322-6027
Fax: 573/441-2197

MENTALLY RETARDED AND DEVELOPMENTALLY DISABLED (MRDD) WAIVER SERVICES FOR THE CENTRAL MC+ MANAGED CARE REGION

Effective March 1, 2001, individuals who participate in the Mentally Retarded and Developmentally Disabled (MRDD) waiver and who meet specific eligibility requirements will be included as MC+ managed care members in the Central Missouri MC+ managed care region. The home and community based waiver services for persons in the MRDD waiver will be carved out of the MC+ Managed Care Program. All other covered services, unless specifically excluded, are the responsibility of the MC+ health plan for MRDD waiver clients enrolled in the MC+ Managed Care Program.

Each person in the MRDD waiver has a service coordinator within the Department of Mental Health (DMH), Division of Mental Retardation and Developmentally Disabled (DMRDD) regional center. The DMH service coordinator is responsible for case managing and coordinating waiver services for the individual.

The DMH service coordinator, the MC+ health plan case manager, and the primary care provider must collaborate on behalf of the client to ensure coordinated care, access to care, and to avoid duplication of services.

Medically necessary physical, occupational, speech and behavioral therapy services for recipients under the age of 21 who are in the MRDD waiver will be the responsibility of the MC+ health plan. These services are covered under the Healthy Children and Youth (HCY) program outside of the MRDD waiver. Medically necessary services, such as speech therapy, occupational therapy, and physical therapy for adaptive training for orthotic and prosthetic devices, that are covered under the Medicaid program for adults will be the responsibility of the MC+ health plan. Speech therapy, physical therapy, occupational therapy, and mental health and substance abuse services outside of the MRDD waiver benefit are the responsibility of the MC+ health plan. Mental health therapy services for MRDD waiver adults are also the responsibility of the MC+ health plan.

The MC+ health plan will be responsible for transportation to services covered by the MC+ Managed Care Program. Transportation covered by the MRDD waiver is limited to services covered under the waiver. (See Section13.25 of the MRDD Waiver manual.)

Targeted case management services for persons in the MRDD waiver are not be the responsibility of the MC+ health plans. These services are reimbursed by the Division of Medical Services on a fee-for-service basis.

HOME BIRTH SERVICES FOR THE MC+ MANAGED CARE PROGRAM

If an MC+ health plan member elects a home birth, the member may be disenrolled from the MC+ managed care program at the request of the MC+ health plan. The disenrolled member will then receive all services through the MC+ fee-for-service program.

The member will remain disenrolled from the MC+ health plan if eligible under the MC+ for Pregnant Women category of assistance. If the member is not in the MC+ for Pregnant Women category and is disenrolled for the home birth, she will be enrolled/re-enrolled in an MC+ health plan six weeks post-partum or after a hospital discharge, whichever is later. The baby will be enrolled in an MC+ health plan once an MC+ number is assigned or after a hospital discharge, whichever is later.

OPT- OUT POPULATIONS FOR THE MC+ MANAGED CARE PROGRAM

MC+ managed care enrollees who receive SSI medical disability benefits, meet the SSI medical disability definition, or receive adoption subsidy benefits do not have to enroll with an MC+ health plan if they so choose. These populations may enroll with an MC+ health plan and later choose to disenroll. If they choose not to enroll or choose to disenroll from the MC+ managed care program, services will be offered through the MC+ fee-for-service program.

CORRECTION TO SPECIAL BULLETIN DATED DECEMBER 1, 2000

Special Provider Bulletin Vol. 23, No. 5, page 3 is corrected as follows: Medically necessary physical, occupational, speech, and behavioral therapy services for recipients under the age of 21 who are in the Mentally Retarded and Developmentally Disabled (MRDD) Waiver will be the responsibility of the MC+ health plan. Medically necessary services, such as speech therapy, occupational therapy, and physical therapy for adaptive training for orthotic and prosthetic devices, that are covered under the Medicaid program for adults will be the responsibility of the MC+ health plan. Mental health therapy services for MRDD waiver adults are also the responsibility of the MC+ health plan.

Special Provider Bulletin Vol. 23, No. 5, Page 5 is corrected as follows: In the second year of the contract, in addition to coordination of benefits, the MC+ health plan shall pursue reimbursement for the above circumstances with the exception of Estate Recovery.

Targeted case management services for persons in the MRDD waiver are not the responsibility of the MC+ health plans. These services are reimbursed by the Division of Medical Services on a fee-for-service basis.